



Emergency Medical Services Administrators and Emergency Medical Directors Associations of California

JOINT POSITION STATEMENT

Medical Control and Alternate Destination and Release from Scene



The Emergency Medical Services Administrators Association of California (EMSAAAC) and the Emergency Medical Directors Association of California (EMDAC) believe:

- Patients access the emergency medical services (EMS) system for many reasons. Not all patients accessing the EMS system want or require transport to an emergency department.
- Current EMS Authority interpretation of statute compel all ambulance transportation to an emergency department regardless of patient need.
- Daily paramedics and emergency medical technicians safely make complex triage decisions in accordance with local EMS medical control policies.
- The vast majority of emergency departments do not have the specialty care resources to properly care for behavioral health patients that require the services of licensed psychiatric facilities.
- Sobriety programs in San Francisco and other communities nationwide have demonstrated that intoxicated persons may be safely managed in a non-acute care setting with proper supervision during the sobering process.
- In California, emergency departments are often overcrowded due in part to the number of behavioral health patients awaiting transfer to a licensed psychiatric facility and with intoxicated persons whose needs could be safely met in a sobering center.
- Ambulance patient destination decisions are and historically have been fully within the medical control authority of the local EMS agency medical director.

Concept:

Develop a process that is consistent with the Emergency Medical Services Authority (EMSA), *"California Statewide Guidelines to Inform Local EMS Policies and Protocols for EMS Response without Patient Transport"* to authorize the assessment and referral of specified patients by paramedics and emergency medical technicians to a County behavioral health designated psychiatric crisis center (PCC) or an authorized sobering center (SC).

Problem Statement:

The medical direction of emergency medical services (EMS) systems has proven effective in developing policies allowing prehospital care personnel to triage complex patients to a variety of specialty care centers designed to meet the specific needs of a wide category of patients. It is a recognized EMS system best practice to triage patients to the facility with the specialized staff and equipment to care for the specific patient's need. However, in California two categories of patients are excluded from receiving the benefits of this best practice – patients in need of psychological services and patients in need of sobering center services.

In 2016, according to data from the Office of Statewide Health Planning (OSHPD) there were more than 14 million hospital emergency department visits in California¹. EMSA, local EMS agencies, and the California Hospital Association all recognize the impact emergency department (ED) overcrowding is having on the delivery of medical services to acutely ill and injured patients throughout the state².

¹ <https://www.oshpd.ca.gov/HID/ED-AS-Data.html#Encounters>

² <https://emsa.ca.gov/wp-content/uploads/sites/47/2017/07/Toolkit-Reduce-Amb-Patient.pdf>

The impact of ED overcrowding is exacerbated when behavioral patients and alcohol-intoxicated individuals whose needs would be best addressed in a PCC or SC are transported instead to an ED. Behavioral health patients and intoxicated individuals often require one-on-one staffing in the ED environment and occupy limited bed and treatment space needed for acutely ill and injured patients. This results in EDs being doubly taxed by the need to care for individuals whose needs would be best met by a PCC or SC. Patients experiencing a psychiatric emergency and/or placed on an involuntary hold and inebriated individuals may be held in the ED from several hours to several days waiting to sober or to be transferred to a PCC. These patients require specialized care and referrals that are not available in the ED. Their very presence adds to the ED overcrowding; decreases the number of ED beds available; which, in turn, delays the off-loading patients and increases the amount of time ambulances and their personnel are held at the hospital.

The EMS Authority has the position that advanced life support (ALS) ambulances operating in the 911 system are required to transport to the ED of an acute care hospital. EMSA has cited various statutes, Health and Safety Code Sections (H&SC) 1797.52 and 1797.218, to support its position that ALS ambulances are required to transport every patient to the ED of an acute care hospital regardless of the level of care required. This interpretation of statute is a significant departure from EMSA's previous position that: "We [EMSA] believe that the reference to 'transport to a general acute care hospital' found in 1797.52 and 1797.218 are permissive and nonspecific. Because of the overriding need to allow flexibility of EMS medical directors, HSC 1797.220 prevails."³

More recently, EMSA has opined that this statute may also apply to basic life support (BLS) ambulances. The EMSA may not be aware of the common, long-standing practice of BLS ambulance companies contracting to transport patients for Department of Mental Health, insurers, and law enforcement to psychiatric facilities.

Coinciding with EMSA's reinterpretation of H&SC 1797.52 and 1797.218, it has been EMSA's push for the use of community paramedic pilot projects as a vehicle for local EMS Agency (LEMSA) oversight and approval of alternate destinations such as transport to a PCC or sobering center. Even though many local EMS agencies had already authorized the use of alternative destinations (e.g., behavioral health crisis centers, sobering centers) since the 1990s, EMSA pressured these local EMS agencies into participating in the community paramedicine pilot projects. EMSA seems to have switched its position without warning or preamble that local EMS agencies did not have the authority to authorize ALS and BLS ambulances to transport patients to alternative destinations outside of EMSA's new community paramedic pilot projects. Though EMSA seemed to have good intentions, this change severely disrupted established safe and effective local medical control policies that had been meeting patient and community needs for many years.

As more fully discussed below, It is the position of the Emergency Medical Services Administrators of California (EMSAAC) and the Emergency Medical Directors Association of California (EMDAC) that the local EMS agency medical director has clear and unambiguous authority under Health and Safety Code Section 1797.220 and 1798 to develop and enact policies to allow for the transport of patients and individuals not requiring evaluation at an acute care emergency department to a psychiatric crisis center or sobering center. Such policies are inherently a triage decision and are not a violation of H&SC 1797.52 or 1797.218, which pertain only to when a demonstrated need for transport to an ED exists. Nor are such policies a deviation from the recognized scope of practice of paramedics and emergency medical technicians.

³ Letter from Joseph Morales, M.D., Director to local EMS agencies dated April 5, 1999

Recent experience with legislation attempting to address alternate destination using the community paramedicine model have been disappointing, highlighting the difficulty of working through the legislative process with its myriad of special interest groups that do not understand the history of EMS systems in California and the role of the LEMSA medical director in ensuring medical control. Senate Bill 944/Hertzberg, the only existing legislative vehicle for keeping community paramedicine projects operating, placed local EMS agencies in an untenable situation. It is unclear if any LEMSA would even consider enacting a community paramedicine program if the legislation passes as written.

Assess and Refer Program (ARP):

A recent document promulgated by the EMSA, "*California Statewide Guidelines to Inform Local EMS Policies and Protocols for EMS Response without Patient Transport*" describes a best practice process for local EMS agencies to establish a standardized approach for "Assess and Refer Protocols" (ARP). It is the intent of local EMS agencies throughout the state to develop and refine their existing policies that allow prehospital care personnel to respond to an incident and perform an assessment and refer the individual to a facility that will best meet the needs of the individual. EMTs and paramedics frequently perform assessments on individuals and release low acuity patients or non-ill/non-injured individuals at scene; or, by use of triage protocols, determine that a patient requires specialized transport to an appropriate hospital (i.e., STEMI, trauma, stroke).

A standardized ARP policy/procedure would be implemented under the existing medical control and CQI models established in each local EMS system which allows prehospital care personnel to respond to calls for service, perform an assessment, and when appropriate not transport the individual. The prehospital patient assessment determines if an acute medical problem exists that requires transport to an emergency department or whether the individual's condition meets criteria to be referred to a destination that will meet their specific needs, which could be a behavioral health crisis center or a sobering center. Essentially, once it is determined that the individual does not require care at an emergency department, local EMS destination policies will guide ambulance personnel to transport the patient to the most appropriate facility that will meet his/her needs. The presumption of a medical emergency no longer applies based on an objective patient assessment performed according to the medical control standards of the local EMS agency.

The goal of ARP is to get the individual to the right place the first time and the emergency department is not always the right place.

Existing Authority

Local EMS agencies are required to exercise "medical control" over their local EMS systems. HS&C 1797.220. They do so under the "direction and management" of a local medical director. HS&C 1798(a). As the California Supreme Court has made clear, the medical control LEMSAs exercise must be construed "in fairly expansive terms, encompassing matters directly related to regulating the quality of emergency medical services" *County of San Bernardino v. City of San Bernardino*, 938 P.2d 876, 887 (Cal. 1997). Local EMS agencies, moreover, *must* "formulate medically related policies and procedures to govern EMS providers." *Valley Med. Transport, Inc. v. Apple Valley Fire Protec. Dist.*, 952 P.2d 664, 668 (Cal. 1998).

Consistent with this statutory responsibility, local EMS agencies have the authority to implement an Assess and Refer programs. EMSA frequently uses 1797.52 (definition of ALS), 1797.114 (EMS Transport Guidelines) and 1797.218 (LEMSA Approval of ALS program) as evidence that an ALS ambulance is required to transport to an acute care hospital. Two of these sections refer to "advanced life support" and the "scene of an emergency"; however, the responses we are discussing do not involve ALS care and once properly assessed, the scene is no longer presumed to be an emergency. HS&C 1797.114, in particular, makes clear that paramedics and EMTs must transport a patient to a medical facility "if the emergency health care needs of the patient dictate

this course of action.” As this language recognizes the need for emergency responders to make qualitative judgments about patient needs and medical conditions, such personnel frequently release individuals at scene after an assessment.

The decision-making that would be required under an ARP would be very similar, except the ambulance is not leaving the individual at scene; they are transporting the individual to a non-acute care facility to receive appropriate care. This concept is consistent with the EMSA’s discussions with EMDAC regarding the establishment of standardized treat and refer guidelines. Objectively, prehospital personnel transporting a patient to a designated facility is conservatively safer than releasing the patient from scene.

The regulations provided in Health and Safety Code, Division 2.5, do not specify any restriction on the use of BLS ambulance transport as it relates to this subject. Thus, local EMS agencies, may under the authority of H&SC 1797.220, develop policies utilizing BLS ambulance transport to any appropriate medical, psychiatric, or other care facility. Indeed, BLS ambulances and even critical care transport (in some cases), transport to dialysis centers, clinics, jails, etc.

Health and Safety Code Sections:

1797.52. (Advanced Life Support) “Advanced life support” means special services designed to provide definitive prehospital emergency medical care, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital as part of a local EMS system at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency or other medical staff of that hospital. (Amended by Stats. 1984, Ch. 1391, Sec. 4.) [Underline added]

1797.88. (Hospital) “Hospital” means an acute care hospital licensed under Chapter 2 (commencing with Section 1250) of Division 2, with a permit for basic emergency service or an out-of-state acute care hospital which substantially meets the requirements of Chapter 2 (commencing with Section 1250) of Division 2, as determined by the local EMS agency which is utilizing the hospital in the emergency medical services system, and is licensed in the state in which it is located. (Amended by Stats. 1986, Ch. 1162, Sec. 1. Effective September 26, 1986.)

1797.114. (EMS Transport Guidelines) The rules and regulations of the authority established pursuant to Section 1797.107 shall include a requirement that a local EMS agency local plan developed pursuant to this division shall require that in providing emergency medical transportation services to any patient, the patient shall be transported to the closest appropriate medical facility, if the emergency health care needs of the patient dictate this course of action. Emergency health care need shall be determined by the prehospital emergency medical care personnel under the direction of a base hospital physician and surgeon or in conformance with the regulations of the authority adopted pursuant to Section 1797.107. (Added by Stats. 1998, Ch. 979, Sec. 4. Effective January 1, 1999.) [Underline added]

1797.218 (Local EMS Agency Approval of ALS & Limited ALS Programs) Any local EMS agency may authorize an advanced life support or limited advanced life support program which provides services utilizing EMT-II or EMT-P, or both, for the delivery of emergency medical care to the sick and injured at the scene of an emergency, during transport to a general acute care hospital, during interfacility transfer, while in the emergency department of a general acute care hospital until care responsibility is assumed by the regular staff of that hospital, and during training within the facilities of a participating general acute care hospital. (Amended by Stats. 1983, Ch. 1246, Sec. 34.) [Underline added]

Proposed ARP Guidelines

In order to promote consistency between local EMS agencies the following is a list of items each medical director should address in establishing an Assess and Refer Plan that include PCC and/or SC:

- Paramedic education hours and curriculum
- Agreements or MOUs between the LEMSA and recognized sobering centers and psychiatric centers addressing:
 - Facility requirements
 - Medical staff
 - Program coordinator
 - Medical training (CPR) and equipment (AED)
 - Quality Improvement including case review and patient disposition
- LEMSA consultation with the County's Public Health Officer or Director of Department of Behavioral Health before entering an agreement or MOU
- Prehospital triage protocols
- Prehospital transfer of care protocol
- Prehospital, sobering center, and psychiatric center documentation
- Tracking and reporting data including patient disposition and outcome